Here we describe a series of 5 cases in which RDN was performed in patients with ESRD and resistant hypertension. The RF energy was delivered using the standard RF delivery system that is used in cardiac electrophysiology lab and a standard 5F, 4mm tip RF ablation catheter was used. Additionally multiple 3 dimensional imaging and catheter monitoring modalities were used to precisely pinpoint the site of RF energy delivery. Dyna CT, a novel 3D imaging tool was used to precisely define the anatomy and annotate the radiofrequency lesions given in a spiral fashion along the length of the arteries. In addition, non fluoroscopic anatomy was created using the NavX Version 3 system.

The procedure was completed without any complications in all 5 patients. The average procedure time was 28 min and average of 5.6 lesions was given in each renal artery. Post procedure renal parameters did not show any significant difference at 48 hrs and at 1 month followup.

There was a significant drop in blood pressure in all the patients 38 ± 18 mmHg in systolic and 16 ± 14 mmHg fall in diastolic BP at 1week follow up and 39 ± 22 mmHg systolic , 18 ± 13 mmHg fall in diastolic BP at 1 month follow up.

To the best of our knowledge, this is the first time in the world that such precision technology has been used to guide this promising new therapy. This also is amongst the first case series of renal failure patients treated with renal denervation. This is also the first report of usage of standard RF ablation catheters for renal denervation and has the potential of widespread usage in labs already equipped with EP systems without any additional expenditure.

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Catheter Ablation of Hemodynamically Unstable Ventricular Tachycardia under Support of Left Ventricular Assist Device

Fei Lu, Ioanna Apostolidou, Kenneth Liao, Ranjit John, Peter Eckman, Gladwin Das, David Benditt, Daniel Garry
University of Minnesota, Minneapolis, MN

Background: Although hemodynamically unstable ventricular tachycardia (VT) may be ablated with the aid of mechanical hemodynamic support, little is known regarding the impact of possible hypo-perfusion of vital organs during such procedures.
Objective: This study investigated whether catheter ablation of unstable VT in the presence of mechanical hemodynamic support may cause acute renal injury.
Methods: Between April 22 2009 and September 14 2012, 15 consecutive patients (aged 63 ± 12 years with left ventricular ejection fraction of 19 ± 9%) who underwent ablation of hemodynamically unstable VT were included in this study. Hemodynamic support included percutaneous (Impella, n=5) and implantable (n=7) left ventricular assist device (LVAD) and percutaneous cardiopulmonary bypass (CPB, n=5).
Results: Except for 2 case in which Impella® was used, hemodynamic support was considered adequate (with consistent mean blood pressure of >60 mmHg). VT was terminated at least once during ablation in all patients. Hemolysis was observed in 1 patient with Impella, and failure to insert Impella due to access problem was encountered in another. Surgical intervention was needed in 2 patients with Impella due to bleeding and entangled Preclose® device, respectively. The mean time under hemodynamic support was 243 ± 96 minutes, and time in VT was 98 ± 67 minutes. There was no significant change in creatinine, blood urea nitrogen, or glomerular filtration rate (GFR) at days 1 and 3 after the procedure compared to baseline values in all patients except one using Impella with bleeding and inadequate hemodynamic support.
Conclusion: Our data suggest that percutaneous CPB and implantable LVAD provide adequate hemodynamic support for ablation of unstable VT as evidenced by unchanged renal function after procedure. Impella, on the other hand, was associated with more complication risk, and may not provide sufficient hemodynamic support in unstable VT patients.

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Efficacy and Safety of Adjuvant Proximal Balloon Inflation Comprising Stent Proximal Edge for Full Expansion of the Stent by Stent Balloon

Seung-Woon Rha, Byoung Geol Choi, Se Yeon Choi, Sung Il Im, Sun Won Kim, Jin Oh Na, Cheol Ung Choi, Hong Euy Lim, Jin Won Kim, Eung Ju Kim, Chang Gyu Park, Hong Seog Seo, Dong Joo Oh
Cardiovascular Center, Korea University Guro Hospital, Seoul, Korea, Republic of

Background: Another shorter & bigger non-compliant balloon is being used for optimal expansion of the stent, particularly the proximal portion of the stent when the proximal and distal reference vessel diameters(RVD) are significantly different. The safety and efficacy of adjuvant proximal balloon inflation (PBI) comprising proximal edge of the stent using stent balloon with higher inflation pressure are largely unknown. This strategy was intended to reduce procedural time, contrast amount and cost when we do the adjuvant ballooning for optimal stent expansion.
Methods: This study consisted of 2164 consecutive patients (pts) underwent percutaneous coronary intervention (PCI) with drug-eluting stents (DESs). A total 211 pts (259 lesions) have performed PBI using same stent balloon. 6-month angiographic and 12-months clinical outcomes were compared between the PBI group and non-PBI group.
Results: The baseline clinical and procedural characteristics were balanced between the two groups, except that the left circumflex lesions were more common in the PBI group. There was no difference in procedural success rate and in hospital complications between the two groups, except that the incidence of peri-procedural myocardial infarction (MI, 5.8% vs. 10.4%, P<0.001) was higher in the PBI group. At 6-month, the follow up minimal luminal diameter (MLD) was smaller in the PBI group. However, this angiographic benefit was not translated into the clinical benefit up to 12 months. (Table).
Conclusion: PBI was associated with higher incidence of peri-procedural MI but other safety profiles, procedural success, in-hospital complications, mid-term angiographic and clinical outcomes were similar with those of non-PBI group. PBI can be a cost-effective strategy when the proximal and distal RVD are significantly different at the time of stent implantation.

Table. Angiographic and Cumulative Clinical Outcomes

Variables, n (%)	Non PBI (n=1834)	PBI (n=200)	p-value
6 to 9 Month Angiographic Outcomes.			
Diameter Stenosis, %	23.9±21.1	24.2±19.8	0.842
Follow up MLD (mm)	2.30±0.77	2.19±0.73	0.082
Late Loss (mm)	0.57±0.64	0.52±0.59	0.332
12-Month Cumulative Clinical Outcomes.			
Total Death	82 (4.4)	10 (5.0)	0.733
Cardiac Death	55 (2.9)	7 (3.5)	0.695
Any MI	26 (1.4)	5 (2.5)	0.235
Q-MI	19 (1.0)	3 (1.5)	0.547
Revascularization	190 (10.3)	19 (9.5)	0.704
TLR	114 (6.2)	14 (7)	0.665
TVR	144 (7.8)	15 (7.5)	0.860
Non-TLR TVR	54 (2.9)	3 (1.5)	0.240
Non TVR	49 (2.6)	4 (2)	0.571
All MACE	267 (14.5)	30 (15)	0.867
Stent thrombosis	24 (1.3)	2 (1.0)	0.712

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Percutaneous Thrombectomy With Primary Coronary Right Judkins 8 French Guide For The Treatment Of Acute Pulmonary Embolism High Risk

Hugo Gutierrez-Leonard, Sr., Jose Luis Ojeda-Delgado, Luis Berumen-Dominguez, Moises Rodriguez-Regino, Violeta Valencia, Miguel Ramirez-Aldaraca, Victor Manuel Diaz de Anda
Hospital Militar, Mexico, Mexico

Objective: A) patency of the pulmonary arteries by thrombus aspiration with right coronary guide catheter. B) Improve the function of the right ventricle. Reduce mortality.
Material: A total of 38 patients, 20 female and 18 male between 28 and 64 years from March 2009 to April 2012. In 37 patients the obstruction was bilateral in all patients, the degree of obstruction was greater than 80% of the main branches. In all cases, introducing a long metal 8 french by 80cm in length and 8 french catheter coronary Judkins guide and a 20ml syringe. the diagnosis was formulated with pulmonary angiotomography echocardiogram.
Method: By puncturing the femoral vein was placed a metal sheath of 8 french by 80cm in length to the trunk of the pulmonary artery and this was passed through a guide catheter handle 4 Judkin right coronary to the site of thrombosis and 20ml syringe practice is sustained suction catheter to remove it slowly withdrawing the introducer. subsequently purging the catheter to remove thrombi were aspirated. This maneuver was repeated several times and finally a practical handbook with this catheter angiography to confirm the patency of the pulmonary branches.
Results: In all cases it was possible achievement for all thrombi. was obtained permeability of the pulmonary branches of 80% saturation was restored and blood pressure in the next few hours. Of the 38 patients, one died during the procedure and another